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Family Medicine

FROM THE EDITOR

Pregnancy Care, the Family Medicine Way

Sarina Schrager, MD, MS

AUTHOR AFFILIATION:

Department of Family Medicine and Community Health, School of Medicine and Public Health, University of Wisconsin, Madison, WI

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As a family physician, being present for the birth of a child and helping the parents and baby thrive is one of the most meaningful and powerful experiences of one's professional practice. When everything goes well, and everyone is healthy, the feeling of being able to impact a new family is inspiring. However, when something goes wrong, or the birthing person needs a cesarean section, or forceps, or magnesium, or when you spend the wee hours of the morning watching a fetal heart rate tracing with decelerations or variables, this process can be incredibly stressful.

Higher-risk pregnancies are more stressful to manage, and data show that rates of pregnancy complications are increasing. The rates of gestational diabetes rose from 6% of all singleton pregnancies in 2016 to 8.3% in 2021.[1] The rate of hypertension in pregnancy has also risen over the last several years (13% in 2017 up to 16% in 2019).[2] Add to the stress of the increased rates of high-risk pregnancies, the unpredictability of labor, interrupted plans, missed life events (eg, piano recitals, birthday parties, graduations), and sleep deprivation, and most family physicians are deciding not to continue practicing.[3] Estimates suggest that only 15% or fewer family medicine residency graduates include obstetrics in their practice.[4] It is just so hard.

Practicing obstetrics appears to both protect against burnout and worsen it.[5] This paradox makes perfect sense. The joy of being present for the delivery of a healthy baby is protective and brings meaning to daily practice. However, the disruption and stress associated with being constantly "on call" for pregnant patients is exhausting and challenging. A paper in this issue of *Family Medicine* describes an open-ended survey of more than 1,500 mid- to late-career clinicians who have kept pregnancy care in their practice for at least 10 years.[6] The survey asks questions about factors that help these clinicians successfully keep obstetrics in their practices. The family physicians who responded describe both barriers to pregnancy care (time, stress, higher acuity pregnancies) as well as facilitators (good relationships with obstetric colleagues, call groups). The respondents also discussed the importance of maintaining work-life balance and adequate training. Maintaining optimum skills focused on obtaining adequate training during residency as well as continuing educational opportunities during practice (taking an advanced life support in obstetrics course or attending the American Academy of Family Phsyicians Family Centered Pregnancy Care conference).

The 4 "C's" of primary care (first **C**ontact, **C**ontinuity, **C**omprehensiveness, and **C**are **C**oordination) exemplify the deep-rooted relationships that family physicians develop with young families.[7] These relationships are vitally important and long lasting. Family physicians see patients for health maintenance visits, to discuss preconception counseling, for prenatal care, during the birth of a child, for newborn care, to discuss issues with breastfeeding, child care, going back to work, discussions of the stress of being a new parent, for postpartum visits, and well-child care. This longitudinal and comprehensive care model is the epitome of what family medicine is and does. We see entire families through the course of their lives.

The Centers for Disease Control and Prevention (CDC) recently reported that one in five birthing people described mistreatment during pregnancy over the last year, with the numbers being significantly higher for Black birthing people (30%) and Latinx birthing people (29%).[8] The people interviewed describe mistreatment as being disrespected, not listened to, being shouted at or scolded, and being coerced into agreeing to certain treatments both during prenatal care and the birthing process. Obviously, this is not acceptable and likely relates, at least in part, to racial bias.

How can family physicians improve the patient experience? Based on the results of the survey by Taylor, et al,[6] organizations can support the work of practicing obstetrics as

a family physician. Leaders can facilitate strong relationships between the obstetricians and family physicians by developing joint working groups and collaborative clinical care guidelines. Practices can assure that family physicians who attend deliveries have adequate time away from their direct patient care if they were up all night and will not be penalized for cancelling a clinic session. Organizations can also provide time and financial support for all family physicians who practice obstetrics to attend continuing education focused on obstetrics. Residencies can enhance training about obstetrics above the basic requirements for anyone who is planning to practice obstetrics after residency and assure confidence in their skills. This enhanced training may include special rotations, conferences, and extra experiences that will support residents who are graduating and planning to include obstetrics in their practice. The ongoing relationships between family physicians and birthing people and their young families have the potential to improve overall pregnancy care. We as a discipline should focus on supporting our colleagues who continue to include obstetrics in their practice.

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